# In Case of Emergency

Child's name: _____ Today's Date: _____

| | | |
|---|---|---|
| Nickname: | Birth date: | |
| Primary language/communication mode: | | |
| Home address: | | |
| Secondary address: | | |
| Parent/Caregiver: | Relationship: | Phone: |
| Parent/Caregiver: | Relationship: | Phone: |
| Emergency Contact: | Relationship: | Phone: |
| Emergency Contact: | Relationship: | Phone: |
| Diagnosis: | | |
| Allergies or dietary restrictions: | | |
| **Relevant health history:** (recent surgery, current status) | | |

| Medications | Dose/Time |
|---|---|
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Medical records are on file at:
Phone:
Fax:

| Hospital Information | | |
|---|---|---|
| **Preferred hospital:**<br>**Address:** | | **Phone:**<br>**ED phone:** |
| **Secondary hospital:**<br>**Address:** | | **Phone:**<br>**ED phone:** |
| **Physician Information** | | |
| **Doctor to call in an emergency:** | **Phone:** | **Fax:** |
| **Primary care doctor:** | **Phone:** | **Fax:** |
| **Specialist:** | **Phone:** | **Fax:** |
| **Specialist:** | **Phone:** | **Fax:** |
| **Specialist:** | **Phone:** | **Fax:** |
| **Preferred Pharmacy** | | |
| **Name:** | **Phone:** | **Fax:** |
| **Insurance Information** | | |
| **Insurance provider:** | **ID#:** | **Phone:** |
| **Important baseline health information:** (vitals, neurologic or cognitive function) | | |
| **My equipment and assistive technology:** (braces/orthotics, walker, wheelchair, communication devices, home $O_2$, insulin pump, suction) | | |
| **Most important things to know about me in an emergency:** (fears, behaviors) | | |
| **Things that calm me down when I am scared or in pain:** (distractions, songs, books, toys, breathing exercises) | | |

This form is available at www.cshcn.org/planning-record-keeping/documents/

Seattle Children's HOSPITAL • RESEARCH • FOUNDATION

Center for Children with Special Needs
www.cshcn.org

Washington State Department of Health

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